

Claimant seeks review of the ALJ's finding that claimant has no permanent disability from her work-related injury. Claimant also raises issues concerning average weekly wage, the liability of respondent for payment of certain medical bills as authorized or unauthorized medical expense, and the ALJ's order denying claimant the opportunity to depose her polygraph examiner.

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

After reviewing the record and considering the arguments, the Appeals Board concludes the Award should be modified. Claimant should be awarded benefits for a 10 percent permanent partial disability.

**Findings of Fact**

- (1) Claimant was employed by respondent nursing home as a CNA. She injured her low back on January 22, 1994 when she lifted a resident from bed.
- (2) Claimant was initially treated by Dr. Trotter who allowed her to continue working on light duty for 6 hours per day. Dr. Trotter referred claimant to Dr. J. Raymundo Villanueva who continued claimant on light duty restrictions and limited her work to 4 hours per day. Thereafter, she treated with Dr. Pedro A. Murati who ultimately released claimant to regular duty work on September 8, 1994.
- (3) During the approximately 9 months that claimant was on light duty she missed many days due to back pain which claimant attributed to her work-related injury. After being released to full duty by Dr. Murati, claimant informed respondent that she did not think she could do all the lifting and bending requirements of her job. As a result, she was terminated.
- (4) Dr. Villanueva first saw claimant on February 24, 1994 and referred her to physical therapy. He found claimant to have limited range of motion of the lumbar spine and a positive straight leg raising test on the right as well as decreased sensation to the right leg.
- (5) Dr. Murati first saw claimant on June 23, 1994. At that time she was having difficulty with standing, walking, sitting, driving, bending, lifting and squatting. She complained of numbness, tingling and weakness. She also complained of swelling in her right foot and ankle and had generalized complaints of low back pain. Dr. Murati diagnosed lumbosacral musculoskeletal strain and morbid obesity. At that time claimant was 5'1" tall and weighed approximately 240 pounds. Upon examination Dr. Murati made objective findings of decreased sensation to the L4 dermatome on the right, increased tone over the distal lumbosacral paraspinal muscles and a positive straight leg raising test on the right. He recommended physical therapy and told claimant to restrict her diet. He gave claimant temporary restrictions for sedentary work only with no lifting, pushing or pulling greater than 10 pounds and no bending, stooping, squatting or crouching.
- (6) On subsequent examinations claimant exhibited similar symptoms and Dr. Murati made similar objective findings but overall Dr. Murati thought claimant's condition was improving. He last saw claimant on September 8, 1994. At that time Dr. Murati had received the results of a functional capacity examination (FCE) which the examiner considered invalid. After discussing the FCE results with claimant, she became upset and

exited his office walking rapidly. He also observed claimant in the parking lot walking to her car and noted that she was "walking very briskly into [sic] her car without any difficulty showing knees with forward flexion in sitting." Dr. Murati recommended a repeat FCE and an MMPI but those were not done. He determined claimant was exaggerating her symptoms and released her from further care with no permanent impairment rating and no restrictions. He did not think claimant was a malingerer, but did believe she was exaggerating her symptoms.

(7) Following her termination by respondent, claimant looked for employment with a few other employers but was unsuccessful in finding work. She eventually stopped looking for work and applied for and received social security disability benefits.

(8) After being released by Dr. Murati, claimant was not provided with any more authorized medical treatment. Claimant sought treatment on her own from several physicians including Dr. Sharon L. McKinney beginning in December 1994. Dr. McKinney diagnosed claimant with chronic back strain and fibromyalgia. In her opinion there were definite physical findings on examination confirming a ligamentous strain and fibromyalgia that could not have been fabricated. In June 1996 Dr. McKinney assigned claimant functional impairment ratings of 10 percent to the body as a whole for fibromyalgia and 3 percent whole body for the SI joint and ligamentous strain together with the slight restriction of internal rotation in the right hip. Her restrictions included no bending, limit carrying to 15 to 20 pounds, walking 15 to 30 minutes 3 to 5 times a day, no squatting, stooping, crawling, or getting in awkward positions. Claimant should also avoid highly repetitive activity, no work above shoulder height, limit stair climbing, and perform only sedentary work that allows her to change positions or tasks every 30 to 45 minutes.

(9) Claimant treated with Dr. McKinney for a time but returned to Dr. Villanueva on January 20, 1997. His diagnosis was acute back pain. Dr. Villanueva recommended physical therapy and a TENS unit and on April 24, 1997 began injections of Marcaine and Depo Medrol. Dr. Villanueva again noted a positive straight leg raising test on the right, limited range of motion and pain with internal rotation of the hip on the right. He obtained a FCE which was interpreted as valid. Based upon the FCE, Dr. Villanueva recommended the following permanent work restrictions: minimal to occasional bending and stooping, no squatting, minimal to occasional crawling, minimal to occasional climbing stairs, no crouching, no kneeling, minimal to occasional balance, lift only 13.3 pounds above shoulder, and 17 pounds up from desk or chair level. He limited claimant to sedentary work with standing and walking no more than 2 hours at a time for a maximum of 2 to 4 hours during the day sitting no more than 2 hours at a time up to 2 to 4 hours during the day, driving 10 to 30 minutes at a time 1 to 3 hours for the day. He did not think claimant could return to her former occupation as a CNA.

(10) Scott Tillotson, one of the physical therapists to whom claimant was referred by Dr. Villanueva, testified that he did not think claimant was faking an injury. He considered

claimant's complaints to be genuine and consistent with a low back injury. Claimant's attendance record at physical therapy was poor, however.

(11) Claimant experienced symptoms of depression from her back pain and employment problems. She was seen by psychiatrist Krishna Lingaiah Rama Das, M.D. Dr. Das met with claimant on two occasions in March of 1996. He diagnosed a pain disorder associated with psychological factors and a general medical condition. He also diagnosed a depressive disorder, personality disorder, and chronic low back pain. He disagreed with Dr. Schlachter that claimant has an anti-social personality disorder. He did not diagnose claimant as a malingerer. In his opinion claimant suffers from a longstanding personality disorder with elements of anxiety or depressive disorder that preexisted her injury at work, but which also predisposed her to the pain disorder and increased depression she has experienced since her work injury.

(12) Respondent sent claimant for an evaluation with psychologist William A. O'Connor, Ph.D. Dr. O'Connor is a clinical psychologist who examined claimant on January 23, 1997 at respondent's request. He diagnosed symptom magnification and somatization disorder. Dr. O'Connor testified that claimant's ability to function was not nearly as impaired as she represented it to be. He considered her tendency to exaggerate her problems to be a symptom of a pre-existing personality disorder. He described this tendency as partly intentional for secondary gain and partly an unintentional means of protecting her self-esteem. Although he considered the psychological factors sufficient to account for all of claimant's physical complaints he did not rule out a physical condition. Dr. O'Connor deferred to the opinions of the medical doctors for that. Many of Dr. O'Connor's conclusions were challenged by claimant's expert psychologist, Dr. Robert W. Barnett.

(13) An independent medical examination was also conducted by Dr. Ernest Schlachter. He examined claimant on February 27, 1995 at the request of the ALJ. He found claimant's complaints of pain and physical limitations to be out of line with his findings on physical examination. He diagnosed a psycho-physiological somatization reaction or conversion hysteria where her symptoms are not related to underlying organic cause. He likewise found claimant suffered from depression but considered the depression to be more related to personal social factors than to any physical condition from the work-related accident. He did not recommend any restrictions and did not give a permanent impairment of function rating to claimant. He testified that claimant fits the criteria of a malingerer.

(14) On October 24, 1995, Dr. P. Brent Koprivica performed an independent medical evaluation on claimant at her attorney's request. He assigned a 10 percent whole body rating pursuant to the AMA Guides to the Evaluation of Permanent Impairment, Third Edition, (Revised) which he attributed to the January 22, 1994 injury. He recommended claimant limit her physical activities to the light physical demand level and avoid repetitive bending, pushing, pulling, twisting or lifting. In his opinion claimant has a chronic lumbosacral strain. He noted, however, that some of claimant's responses to his

examination were non-anatomic and inappropriate. He also diagnosed a chronic somatoform pain disorder which he said is a psychologically impairing condition. From a physical standpoint, Dr. Koprivica considered claimant capable of engaging in gainful employment and would encourage her to do so. He was not sure she was psychologically capable of engaging in gainful employment, however.

(15) Vocational expert Monty Longacre prepared a list of claimant's work tasks for the relevant 15 year period before her accident. After reviewing that list, Dr. Koprivica opined claimant had lost 58 percent of those tasks. Dr. Koprivica's initial opinion was that claimant's task loss was 25 percent. According to Dr. McKinney there were no tasks that claimant could still perform without qualification or job modification. Dr. Das is of the opinion that claimant is totally disabled from performing work and therefore has lost 100 percent of her job tasks performing ability.

(16) Claimant initially made some attempt to find work after her termination by respondent. She applied at Kentucky Fried Chicken, Muchas Boots, McDonald's, Long John Silver's and some other places which she could not recall. She registered at the Job Service Center. At the time of her deposition she had not checked with Job Service for about a month.

(17) On the date of accident, claimant was a full-time employee earning \$5.36 per hour. This computes to an average weekly wage of \$214.40. During oral argument and in the parties' briefs to the Board this figure did not appear to be in dispute.

(18) The ALJ awarded an unauthorized medical expense of \$500 for respondent's expert, Dr. O'Connor. This was error. K.S.A. 44-510(c) allows claimant up to \$500 for unauthorized medical expense. Respondent agrees it was error to award the unauthorized medical expense for its expert. Respondent objects, however, to any award for unauthorized medical as one of the physicians for whom claimant requests authorized medical expense, Dr. McKinney, provided an impairment rating to claimant. Respondent does not say why claimant would not be entitled to unauthorized medical for payment to Dr. Das. As Dr. Das did not assign an impairment rating, his bills are eligible for payment under the unauthorized medical allowance up to the maximum amount. In addition, claimant saw Dr. McKinney for purposes of treatment before Dr. McKinney was asked to give an opinion on impairment. Accordingly, Dr. McKinney's charges for medical treatment separate and apart from her charges for giving an opinion on impairment of function and serving as an expert medical witness, would be eligible for payment under the statutory unauthorized medical allowance provision in K.S.A. 44-510(c).

(19) Claimant hired Mr. Gary F. Davis to administer a polygraph examination to claimant. Thereafter, claimant scheduled Mr. Davis' deposition for March 17, 1997. On March 10, 1997 respondent filed a motion to quash the deposition of Mr. Davis. On that same day respondent hand delivered a copy of its motion to claimant's counsel. There is no record but according to claimant's counsel the ALJ conducted a hearing on

respondent's motion that same day, over claimant's objection. Claimant's counsel objected to the lack of notice and to the absence of a court reporter. The ALJ then issued an order dated March 17, 1997 granting claimant's motion to continue the hearing on respondent's motion to quash and stayed the deposition until after the motion to quash could be heard. A second hearing on the motion was held June 24, 1997 and the ALJ granted respondent's motion to quash the deposition.

#### Conclusions of Law

- (1) Claimant has the burden of proving his/her right to an award of compensation and of proving the various conditions on which that right depends. K.S.A. 44-501(a).
- (2) The Board finds that claimant's injury resulted in a functional impairment of 10 percent. This finding is based primarily on the testimony of Dr. Koprivica.
- (3) Based upon the opinion of Dr. Das, the Board finds that claimant's pain disorder and depressive disorder were caused or aggravated by her work-related injury. She is, therefore, entitled to medical treatment for these conditions, as well as for her low back condition, upon application to and approval by the Director.
- (4) The Board further finds that claimant has the ability to engage in substantial gainful employment and is not totally disabled. K.S.A. 44-510c(a)(2).
- (5) K.S.A. 44-510e(a) defines work disability as the average of the wage loss and task loss:

The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury.

- (6) K.S.A. 44-510e also specifies that a claimant is not entitled to disability compensation in excess of the functional impairment so long as the claimant earns a wage which is equal to 90 percent or more of the preinjury average weekly wage.
- (7) The wage prong of the work disability calculation is based on the actual wage loss only if claimant has shown good faith in efforts at obtaining or retaining employment after the injury. Claimant may not, for example, refuse to accept a reasonable offer for accommodated work. If the claimant refuses to even attempt such work, the wage of the accommodated job may be imputed to the claimant in the work disability calculation. Foult v. Colonial Terrace, 20 Kan. App. 2d 277, 887 P.2d 140 (1994), *rev. denied* 257 Kan. 1091

(1995). Even if no work is offered, claimant must show that he/she made a good faith effort to find employment. If the claimant does not do so, a wage will be imputed to claimant based on what claimant should be able to earn. Copeland v. Johnson Group, Inc., 24 Kan. App. 2d 306, 944 P.2d 179 (1997).

(8) The Board concludes that claimant has not proven that she made a good faith effort to find appropriate employment. The Board, therefore, would impute to claimant the ability to earn the minimum wage of \$5.15 per hour for a 40-hour week, for a weekly wage of \$206, or more than 90 percent of her preinjury wage.

(9) Claimant is, therefore, awarded benefits based on the 10 percent functional impairment. K.S.A. 44-510e.

(10) Claimant sought to take the deposition of Gary Davis, a private investigator who conducted a polygraph test of claimant. In Kansas district courts the general rule is that the results of a polygraph examination and the proposed deposition of the polygraph examiner are not admissible absent a stipulation by the parties. State v. Ulland, 24 Kan. App. 2d 249, 943 P.2d 947 (1997). But that rule of evidence is not applicable to workers compensation cases. Armstrong v. City of Wichita, 21 Kan. App. 2d 750, 907 P.2d 923 (1995). The issue concerning the admissibility of the polygraph test results, however, is moot. Claimant sought to introduce the polygraph evidence to show that she was telling the truth about her injury and symptoms. During oral argument to the Board, respondent's counsel conceded that claimant probably believed that she was still injured and that her symptoms were real to her. This concession satisfies claimant's purpose for offering the polygraph test results and the testimony of Mr. Davis is unnecessary.

### **AWARD**

**WHEREFORE**, it is the finding, decision, and order of the Appeals Board that the award entered by Administrative Law Judge Kenneth S. Johnson dated February 20, 1998, should be, and is hereby, modified.

**WHEREFORE, AN AWARD OF COMPENSATION IS HEREBY MADE IN ACCORDANCE WITH THE ABOVE FINDINGS IN FAVOR** of the claimant, Julia Urquidi, and against the respondent, Trinity Manor Adult Care Home, and its insurance carrier, Kansas Association of Homes of the Aging, for an accidental injury which occurred January 22, 1994, and based upon an average weekly wage of \$214.40 for 4.71 weeks of temporary total disability compensation at the rate of \$142.94 per week or \$673.25, followed by 41.5 weeks at the rate of \$142.94 per week or \$5,932.01, for a 10% permanent partial general disability, making a total award of \$6,605.26, which is all due and owing and ordered paid in one lump sum less any amounts previously paid.

Respondent is ordered to pay all reasonable and related authorized medical expenses.

Future medical is awarded upon proper application to and approval by the Director.

An unauthorized medical allowance of up to \$500 is awarded upon presentation to respondent of an itemized statement verifying same.

Claimant's attorney fee contract is hereby approved insofar as it is not inconsistent with K.S.A. 44-536.

The fees necessary to defray the expense of the administration of the Workers Compensation Fund are assessed against the respondent to be paid as follows:

Underwood & Shane	
Transcript of Proceedings	\$ 99.50
Transcript of Proceedings	154.00
Transcript of Proceedings	94.00
Deposition of Barbara Schroeder	245.50
Deposition of Dr. Das	653.50
Deposition of Scott Tillotson	300.25
Deposition of Keith Bailey	153.75
Deposition of Dr. Villanueva	303.75
Deposition of Charlotte Villela	144.75
Deposition of Mitch Bremer	180.00
Deposition of Julie Urquidi	364.50
Gene Dolginoff Associates, LTD	
Deposition of Dr. Koprivica	\$522.50
Barber & Associates	
Deposition of Dr. Schlachter	\$253.00
Deposition of Dr. Barnett	241.60
Deposition of Dr. Murati	329.00
Advanced Court Reporting Services	
Deposition of Charlotte Villela	\$ 95.00
Deposition of Matilda Camacho	87.50
Susan Maier, CSR	
Preliminary Hearing	\$ 77.52
Preliminary Hearing	206.10
Hostetler & Associates, Inc.	
Deposition of Dr. O'Connor	\$555.60
Hutchison Court Reporting	
Deposition of Monty Longacre	\$112.00
Correll Reporting Service	
Deposition of Dr. McKinney	\$328.00

**IT IS SO ORDERED.**

Dated this \_\_\_\_ day of April 1999.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Diane F. Barger, Wichita, KS  
Thomas W. Young, Dodge City, KS  
Office of Administrative Law Judge, Garden City, KS  
Philip S. Harness, Director